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Attorneys for Complainant

BEFORE THE

MEDICAL BOARD OF CALIFORNIA

DIVISION OF MEDICAL QUALITY

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against: STEPHEN HERMAN, M.D. 9341 Hazel Circle Villa Park, CA 92667 Physician and Surgeon License No. A20234 and VALENTINE BIRDS, M.D. 12626 Riverside Dr., Ste. 510 North Hollywood, CA 91607 Physician and Surgeon License No. A28695 Respondents.	CASE NOS. D-4512, AND D-4513 OAH NOS. L-53519, AND L-53520 STIPULATION FOR VOLUNTARY SURRENDER OF LICENSE

IT IS HEREBY STIPULATED AND AGREED by and between Complainant, Kenneth J. Wagstaff, Executive Director of the Medical Board of California (herein after "Board"), and Stephen

Herman, M.D. (herein after "Respondent Herman"), parties to the above-entitled matter, that:

1. Kenneth J. Wagstaff, Complainant, is the Executive Director of the Medical Board of California and is represented by Daniel E. Lungren, Attorney General of the State of California by Roy W. Hewitt, Deputy Attorney General.

2. Respondent Herman is represented in this administrative disciplinary proceeding before the Board by Andrew Lloyd, Esq. Respondent Herman has counseled with Attorney Lloyd concerning the effect of this stipulation, which Respondent Herman has carefully read and fully understands.

3. At all times mentioned herein Respondent Herman has been licensed by the Board under Physician and Surgeon License No. A20234. Said License was issued by the Board on July 9, 1962.

4. On or about May 17, 1991, Complainant, in his official capacity as Executive Director of the Board, filed Accusation No. D-4152; OAH No. L-53519 against Respondent Herman. A true and correct copy of Accusation No. D-4512; OAH No. L-53519 is attached hereto as Attachment "A" and incorporated by reference as if fully set forth herein. On or about May 17, 1991, Respondent Herman was served with Accusation No. D-4512; OAH No. L-53519 together with all other statutorily required documents, at his address of record on file with the Board: 9341 Hazel Circle, Villa Park, California 92667.

Respondent Herman is fully aware of the charges and allegations contained in Accusation No. D-4512; OAH No. L-53519,

having been fully advised of the allegations by his attorney of record, Andrew Lloyd, Esq. Respondent Herman understands that the charges and allegations contained in Accusation No. D-4512; OAH No. L-53519 would, if proven, constitute cause for imposing discipline upon his physician and surgeon license.

5. Respondent Herman is fully aware of his right to a hearing on the charges and allegations contained in Accusation No. D-4512; OAH No. L-53519, his right to reconsideration, appeal, and any and all other rights which may be accorded him pursuant to the California Administrative Procedure Act and California Code of Civil Procedure, having been fully advised of same by attorney, Andrew Lloyd, Esq.

6. Respondent Herman, having the benefit of counsel, hereby freely, voluntarily, and intelligently waives his rights to a hearing, reconsideration, appeal, and any and all other rights which may be accorded him pursuant to the California Administrative Procedure Act and California Code of Civil Procedure with regard to Accusation No. D-4512; OAH No. L-53519.

7. Respondent Herman understands that by signing this stipulation, rather than contesting the charges and allegations contained in Accusation No. D-4512; OAH No. L-53519, he is enabling the Board to issue its order accepting the voluntary surrender of his physician and surgeon license without any further notice, opportunity to be heard, or formal proceeding.

8. Respondent hereby voluntarily surrenders his Physician and Surgeon License No. A20234 to the Medical Board of California for its formal acceptance.

9. Upon acceptance of this stipulation by the Board, Respondent agrees to surrender and cause to be delivered to the Board his wallet certification and his physician and surgeon license certificate.

10. Respondent Herman fully understands that when the Board accepts the voluntary surrender of his Physician and Surgeon License No. A20234, he will no longer be permitted to practice as a physician and surgeon within the State of California.

11. In consideration for the foregoing stipulations, admissions, and recitals, the Board, upon formal acceptance of Respondent Herman's formal surrender herein, agrees to dismiss with prejudice, Accusation No. D-4512; OAH No, L-53519, currently pending against Respondent Herman.

12. Respondent Herman fully understands that should he ever reapply for a physician and surgeon license, in the State of California, all the charges and allegations contained in Accusation No. D-4512; OAH No, L-53519 shall be deemed admitted by Respondent Herman as true and correct for purposes of any statement of issues or other proceedings seeking to deny such reapplication by Respondent.

13. Respondent Herman further stipulates that the Interim Order of suspension currently in effect shall remain in effect until either the board accepts respondent's voluntary surrender of his license; or, until a decision issues after hearing on accusation, if the board rejects the offer of license surrender.

14. This stipulation for voluntary surrender of Respondent Herman's physician and surgeon license is intended by the parties to be an integrated writing memorializing the complete agreements of the parties herein.

14. In the event this stipulation is rejected, for any reason, by the Medical Board of California, it will be of no force or effect for either party.

DATED: July 9, 1991.

DANIEL E. LUNGREN, Attorney General
of the State of California

Roy W. Hewitt

ROY W. HEWITT
Deputy Attorney General

Attorneys for Complainant

DATED: July 24, 1991.

ANDREW LLOYD
Attorney for Respondent

ACKNOWLEDGEMENT

I, Stephen Herman, have read the stipulation in Case No. D-4512; OAH No. L-53519 and enter into the stipulation for voluntary surrender of my physician and surgeon license freely, voluntarily, intelligently, on advice of counsel, and with full knowledge of its force and effect, and do hereby surrender my Physician and Surgeon License No. A20234 to the Medical Board of California for its formal acceptance. By so surrendering my license, I recognize that upon formal acceptance of the surrender by the Board, I will lose all rights and privileges to practice as a physician and surgeon in the State of California.

DATED: 7/29, 1991.

STEPHEN HERMAN
Respondent

ORDER

The voluntary surrender of Physician and Surgeon License No. A20234, by Respondent Stephen Herman, is accepted by the Medical Board of California. Accusation No. D-4512; OAH No. L-53519 is dismissed with prejudice.

This decision shall become effective the 12th day of March, 1992.

So ordered this 11th day of February, 1992.

Theresa Classen

Medical Board of California
Division of Medical Quality
Department of Consumer Affairs
State of California

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In the Matter of the Accusation Against:	CASE NOs. D-4512, and D-4513
STEPHEN HERMAN, M.D. 9341 Hazel Circle Villa Park, CA 92667 Physician and Surgeon License No. A20234	OAH NOs. L-53519, and L-53520
and	ACCUSATION
VALENTINE BIRDS, M.D. 12626 Riverside Drive, Ste. 510 North Hollywood, CA 91607 Physician & Surgeon License No. A28695	
Respondents.	

COMES NOW Complainant Kenneth Wagstaff, who as cause for disciplinary action, alleges:

1. Complainant is the Executive Director of the Medical Board of California (hereinafter the "Board") and makes and files this accusation solely in his official capacity.

LICENSE STATUS

2. On or about July 9, 1962, Physician and Surgeon Certificate No. A20234 was issued by the Board to Stephen Herman, M.D. (hereinafter "respondent Herman"), and at all times relevant herein, said Physician and Surgeon Certificate was in full force and effect.

3. On or about March 21, 1975, Physician and Surgeon Certificate No. A28695 was issued by the Board to Valentine Birds, M.D. (hereinafter "respondent Birds"). On June 14, 1978, respondent Birds was subject to discipline for unprofessional conduct pursuant to Business and Professions Code sections 490, 2141, and 2392 (aiding and abetting unlicensed persons to practice medicine). Respondent Birds' license was revoked with the revocation stayed. Respondent Birds was placed on five years probation on certain terms and conditions including actual suspension for sixty days. Probation terminated and respondent's license was fully restored to unrestricted status on december 28, 1980. Additionally, respondent Birds is a supervisor of a physician assistant, License No. SA16055.

STATUTES

4. This accusation is made in reference to the following sections of the California Business and Professions Code (hereinafter "Code"):

a. Code section 2220 provides, in pertinent part, that the Board may take action against all persons guilty of violating the Medical Practice Act.

b. Code section 2227 provides that the Board may

revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act.

c. Code section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting a violation of, or conspiring to violate any provision of this Chapter.

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

FACTS

DEVELOPMENT OF "VIROXAN"

5. "Viroxan", also referred to as LP-1, LP-4, Geraniol, Linolool, and Linolool Ozonide, was first "synthesized" from plant sources by respondent Herman and Herman's son in 1988.

6. At all times relevant herein, respondent Herman and others "manufactured" quantities of "Viroxan" in a "primitive" laboratory located in the kitchen of respondent Herman's

residence.

7. "Viroxan" has never received approval by the United States Food and Drug Administration (USFDA), or the Food and Drug Branch of the California Department of Health Services, or any other regulatory agency as being safe and efficacious for use against HIV infections (AIDS) in human beings.

8. On or about, and before September 1, 1989, respondent Herman and respondent Birds were aware that "Viroxan" was not proven safe for use in human beings or efficacious against AIDS infection HIV, infection or any bacterial, fungal, or viral infections. Nonetheless, prior to receiving even basic animal toxicity data, respondents Herman and Birds began injecting human beings with "Viroxan".

9. Respondent Herman and respondent Birds failed to heed the warnings of Dr. Herman's scientific consultant Dr. K. concerning the fact rubber stoppers on the vials containing "Viroxan", manufactured and bottled in respondent Herman's kitchen, were not airtight; they leaked and were therefore subject to contamination. Furthermore, Dr. K. informed respondent Herman that "Viroxan" had a toxic effect on animals at doses greater than 1.9mm (107mg/kg). In fact doses greater than 1.9mm killed all test mice and rats; and, rabbits experienced adverse reactions at the "Viroxan" injection site.

UNDERCOVER OPERATIONS

INVESTIGATOR COLBY S.

10. On or about December 27, 1989, Colby S., a Senior Special Investigator for the Medical Board of California called

respondent Birds and told respondent Birds he had just been tested HIV positive and was interested in receiving treatment. Respondent Birds told Colby S. he used typhoid therapy. Respondent Birds then referred Colby S. to respondent Herman to discuss treatment. Respondent Birds gave Colby S. respondent Herman's telephone number and represented to Colby S. that respondent Herman had good results treating AIDS patients with "Viroxan".

11. On or about January 8, 1990, Colby S. contacted respondent Herman via telephone and explained to respondent Herman that Colby S. was interested in hearing about respondent Herman's treatment for AIDS. Respondent Herman told Colby S. to come to respondent Herman's home the next day at 11:00 a.m.

12. On or about January 9, 1990, Colby S. and approximately five other individuals attended a two-hour presentation conducted by respondent Herman at respondent Herman's home. During the presentation respondent Herman informed the group that other AIDS treatments were ineffective, but his treatment with "Viroxan" has long-term effects in arresting the disease. Respondent Herman claimed treatment with "Viroxan" produced no side-effects and that "Viroxan" had been tested and found non-toxic and effective against a wide spectrum of diseases. Respondent Herman recommended to the group that any patient receiving "Viroxan" be referred to respondent Birds so respondent Birds could arrange surgery for placement of Hickman catheters.

13. Respondent Herman told attendees that treatment

with "Viroxan" requires daily injections, and a thirty-day supply costs three hundred dollars. Respondent Herman also told the group it would be unnecessary for them to return to see respondent Herman except to pick up more "Viroxan" because patients could self-inject the "Viroxan".

14. On or about January 11, 1990, pursuant to arrangements made at the previous days seminar, Colby S. purchased ten vials of "Viroxan" from respondent Herman for three hundred dollars. As soon as the sale occurred respondent Herman was arrested by the authorities.

15. As a result of the conduct described in Paragraphs 5-14 above, respondent Herman and respondent Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (e) because of their acts of dishonesty and/or corruption in willfully and unlawfully representing "Viroxan" as being effective in treating HIV positive patients, AIDS patients, and patients with diseases, disorders, or conditions of the immune system with the intent to defraud or mislead the individuals to whom the representations were made.

16. As a result of the conduct described in Paragraphs 5-14 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in making available for self-administration a foreign substance not shown to be safe for use in human beings or efficacious against HIV infection.

17. As a result of the conduct described in Paragraphs 5-14 above, respondent Herman is subject to disciplinary action

pursuant to Code section 2234, subdivision (b) because of his gross negligence in making available to patients, a substance ("Viroxan"), which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

18. As a result of the conduct described in paragraphs 5-14 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (d) because of his incompetence in making available for patients' self-administration, a foreign substance not shown to be safe for use by human beings or efficacious against HIV infection.

19. To the extent it is determined respondent Birds aided and abetted respondent Herman in the above-described conduct, respondent Birds is also subject to discipline pursuant to section 2234, subdivisions (b), (d), and (e) because of his gross negligence, incompetence, dishonesty or corruption.

INVESTIGATOR JEFFREY Y.

20. On or about January 10, 1990, Jeffrey Y., a Food and Drug Investigator called respondent Herman's home and arranged to attend a "Viroxan" presentation set to occur at 11:00 a.m. on January 11, 1990.

21. On or about January 11, 1990, Investigator Jeffrey Y. attended a presentation on "Viroxan" conducted by respondent Herman at respondent Herman's home. During the presentation, respondent Herman represented "Viroxan" to be a "break through" "clearly demonstrated" to be effective in treating the entire spectrum of T-cell mediated diseases. Respondent Herman further

represented that "Viroxan" was proven non-toxic, and was effective in treating chronic, long-term arthritis and cancers such as Hodgkin's Disease and leukemia.

22. As a result of the conduct described in Paragraphs 5-9 and 20-21 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (e) because of his dishonest and/or corrupt representation that "Viroxan" was safe and effective for treatment of T-cell mediated diseases, chronic, long-term arthritis and cancers.

PATIENT TREATMENT WITH "VIROXAN"

PATIENT MARK S.

23. On or about December 1, 1988, Mark S., an HIV infected individual, became a patient of respondent Birds. On that day, respondent Birds gave Mark S. a "typhoid skin test".

24. On or about December 5, 1988, respondent Birds began Mark S. on a "therapeutic protocol using typhoid vaccine."

25. On or about, and between approximately December 5, 1988 and March 21, 1989, Mark S. kept approximately thirteen separate appointments with respondent Birds during which Mark S. received varying amounts of typhoid vaccine for treatment of his HIV infection.

26. On or about August 17, 1989, Mark S. had a CD4-T-cell measurement of 132 cells/Cumm. It was recommended by the Staff at Philip Mandelker AIDS Prevention Clinic of the Gay and Lesbian Services Center in Hollywood that Mark S. consider treatment with Zidovudine (formerly known as AZT) and receive primary prophylaxis against the development of Pneumocystic

Pneumonia.

27. On or about September 5, 1989, Mark S. gave a copy of his latest CD4-T-cell count to respondent Birds. Respondent Birds administered more typhoid vaccine and made no recommendation concerning use of Zidovudine or primary prophylaxis against development of Pneumocystic Pneumonia.

28. On or about October 13, 1989, pursuant to respondent Birds recommendation, Mark S. contacted and visited respondent Herman at respondent Herman's home in Orange County. Respondent Herman noted that Mark S. had a CD4-T-cell count of 132 cells-/cu.mm. and "thrush moderate Lymphadenopathy, SlGI upset, fatigue, herpes recurrent and hair loss." Accordingly, respondent Herman began Mark S. on "Viroxan" via intravenous injection.

29. On or about October 16, 1989, to facilitate injection of the "Viroxan" supplied by respondent Herman, respondent Birds recommended Mark S. have a Hickman catheter surgically implanted.

30. On or about October 17, 1989, Mark S. was admitted to the Medical Center of North Hollywood where a Hickman catheter was placed pursuant to respondent Birds' order. Respondent Birds indicated the need for placement of a Hickman catheter was due to his professional diagnosis of "lymphoma".

31. On or about October 18, 19, 20, 23, and 31, 1989, Mark S. visited respondent Birds. On each of the five visits, respondent Birds supplied Mark S. with quantities of "Viroxan" IV.

32. On or about October 26, 1989, Mark S. again saw respondent Herman and was given "4,000 mg IV" of the substance "Viroxan."

33. On or before October 31, 1989, Mark S. was experiencing severe breathing problems and was acutely ill. Respondent Birds noted Mark S. had nausea and vomiting for three days. Nonetheless, respondent Birds failed to perform a physical examination nor did he draw any blood from Mark S. for laboratory analysis. Rather, respondent Birds infused "Viroxan" via Mark S.'s Hickman catheter and dispensed additional amounts of "Viroxan" to Mark S. so Mark S. could self-infuse the "Viroxan" at home.

34. On or about November 5, 1989, (a Sunday) Mark S. visited respondent Birds at respondent Birds' office. Mark S. complained of "total body numbness and pain." Without performing a physical examination, respondent Birds gave Mark S. some Cipro (an antibiotic used to treat urinary tract infection), and recommended Mark S. continue with "Viroxan".

35. On or about November 8, 1989, Mark S. was found lying immobile in his bath tub at approximately 2:30 a.m. Mark S. had been in the bath tub for several days. The paramedics were called. After the paramedics arrived, respondent Birds was contacted to get approval for transporting Mark S. to the hospital. Respondent Birds did not give his approval for transportation to the hospital.

36. On or about November 8, 1989, at approximately 4:30 a.m., respondent Birds was again called and informed that

Mark S.'s condition was worsening. Again, respondent Birds failed to recommend hospitalization. Instead, respondent Birds indicated Mark S. would be fine and just to keep an eye on him.

37. On or about November 8, 1989, at approximately 7:00 a.m., respondent Birds was called for the third time and informed that Mark S. needed immediate medical attention. Respondent Birds promised to call for an ambulance. However, two hours later, respondent Birds arrived at Mark S.'s apartment and informed those present that he had just called for an ambulance. It was not until approximately 9:00 a.m. that morning that the paramedics arrived to transport Mark S. to Queen of Angels Hollywood Presbyterian Medical Center. Mark S. was admitted to that hospital at approximately 10:10 a.m. with signs of septicemia, meningitis, dehydration, pneumonitis, and rhabdomyolysis due to prolonged immobilization. Mark S.'s CD4+ T-cell count demonstrated Mark S.'s immunodeficiency.

38. Despite treatment, Mark S.'s condition continued to deteriorate. A chest X-ray taken on or about November 11, 1989, revealed bilateral pulmonary infiltrates.

39. On or about November 12, 1989, Mark S. suffered a respiratory arrest and was intubated. Cardiac arrest quickly followed and Mark S. died at 6:13 a.m. on November 12, 1989.

40. An autopsy on Mark S. revealed the presence of an extensive bilateral staphylococcal cavitating pneumonia together with a bilateral pneumocystis cariini pneumonia. Staphylococcal infection was also noted in other organs of Mark S.'s body, including but not limited to acute staphylococcal inflammation of

the diaphragm and bilateral extensive necrotizing staphloycoccal nephritis. Cerebrospinal fluid cultures also yielded staphylococcus aureus.

41. Respondents Herman and Birds are subject to disciplinary action pursuant to section 2234, subdivisions (b), (d), (e) based on their gross negligence, incompetence, and dishonesty or corruption in recommending and referring Mark S. to a surgeon for insertion of a Hickman catheter without adequate medical indication, especially when respondents knew, or should have known that Mark S. was severely immunocompromised. Respondents failed to properly advise Mark S. of the potential lethal complications of such a procedure and the extremely low likelihood of any benefit.

42. As a result of the conduct described in Paragraphs 23-40 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivision (d) because of his incompetency in using typhoid vaccine without proper medical indication.

43. As a result of the conduct described in Paragraphs 5-9 and 23-40 above, respondents Herman and Birds are subject to disciplinary action pursuant to section 2234, subdivisions (b), (d) and (e) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.

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44. As a result of the conduct described in Paragraph 5-9 and 23-40 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their numerous acts of gross negligence in administering and/or making available to patients, a substance ("Viroxan"), which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

45. As a result of the conduct describe in Paragraphs 23-40 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their gross negligence in treating an AIDS patient by self-administered intravenous infusion, their failure to instruct the patient on proper sterile injection technique, and their failure to monitor a patient's home use of a foreign substance by parenteral delivery.

46. As a result of the conduct described in Paragraphs 5-9 and 23-40 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their gross negligence in failing to obtain investigational approval, as required by law, from regulatory agencies prior to administering the substance "Viroxan" to human beings.

47. As a result of the conduct described in Paragraphs 26-27 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of their gross negligence and incompetence in

failing to timely recognize the presenting symptoms of Pneumocystis cariini pneumonia (PCP), and failing to initiate chemoprevention against PCP.

48. As a result of the conduct described in Paragraphs 23-40 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of their gross negligence and incompetence in failing to perform a physical examination, take an adequate medical history, or formulate a treatment plan based on a diagnosis of Mark S.'s ailment(s).

49. As a result of the conduct described in Paragraphs 23-40 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (c) because of their repeated negligent acts in failing to keep adequate medical records of their treatment of Mark S., their failure to make professional assessment of Mark S.'s medical condition, their failure to instruct Mark S. on proper sterile injection techniques, their failure to monitor his use of a foreign substance, their failure to present Mark S. with options other than the substance "Viroxan" for treatment of HIV infection, their failure to monitor Mark S.'s medical condition, and their failure to refer Mark S. to a recognized medical specialist.

50. As a result of the conduct described in Paragraph 33-37 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in failing to immediately hospitalize Mark S.

PATIENT ROBERT H.

51. On or about August 3, 1989, Robert H., an HIV infected individual became a patient of respondent Birds.

52. On or before August 15, 1989, Robert H. complained to respondent Birds of chills, fever, and sweats.

53. From approximately August 1989 through October 1989, respondent Birds saw Robert H. on a regular basis. Respondent Birds treated Robert H.'s HIV infection with "a therapeutic protocol using typhoid vaccine".

54. On or about October 3, 1989, Robert H. again complained to respondent Birds about night sweats and chills. Respondent Birds attributed Robert H.'s problem to the typhoid vaccine and failed to consider other diagnostic explanations for the development of night sweats and chills in Robert H., an HIV positive patient.

55. On or about October 16, 1989, test results indicated Robert H. was at risk of developing pneumocystis cariini pneumonia (PCP). Rather than recommending medication to treat or prevent PCP, respondent Birds instead recommended "Aloe Vera Juice."

56. At no time after Robert H.'s initial examination, on or about August 7, 1989, was Robert H. given a physical examination. In fact, during office visits which occurred after August 7, 1989, respondent Birds did not even record Robert H.'s temperature.

57. Pursuant to respondent Birds recommendation, on or about October 17, 1989, Robert H. was seen by respondent Herman.

Respondent Herman took a very brief medical history noting Robert H. was "HIV positive", but respondent Herman did not perform a physical examination, formulate a treatment plan, nor recommend measures to prevent PCP, despite the fact Robert H. had a low CD4+ T-cell count.

58. Respondent Herman began treating Robert H. with "Viroxan" on or about October 17, 1989.

59. Respondent Herman and respondent Birds arranged for Robert H. to have a Hickman catheter surgically placed on or about October 24, 1989.

60. On or about October 24, 1989, Robert H. had a double-lumen Hickman catheter implanted. Respondent Birds indicated the reason for placement of the Hickman catheter was "for chemotherapy for his lymphoma."

61. While Robert H. was undergoing continuous treatment by respondents Herman and Birds with "Viroxan", he visited respondent Birds on or about October 30, 1989, because Robert H. was suffering flu-like symptoms which respondent Birds believed may have been associated with the "Viroxan". Respondent Birds also believed Robert H.'s cough, fever, night sweats, chills and breathing problems might be due to a lower respiratory tract infection-PCP, the most common illness in HIV infected individuals with low CD4+ T-cell levels.

62. On or about November 6, 1989, Robert H. had a chest X-ray taken at San Pedro Peninsula Hospital. The X-ray revealed "evidence of bilateral intersticial disease greater on the left than the right. This likely represents an infectious

etiology. Corrolation W/prior chest X-ray is recommended." Robert H. was too ill to go see respondent Birds, so, based on telephone communication, respondent Birds prescribed inadequate doses of Bactrim to treat Robert H.'s PCP, even though respondent Birds was aware Robert H. was allergic to sulpha. Respondent Birds ordered Robert H. to take the Bactrim at home through his Hickman catheter.

63. Robert H.'s condition continued to deteriorate. Accordingly, on or about November 8, 1989, via telephone, respondent Birds ordered Robert H. receive supplemental oxygen by nasal cannula at home. Respondent Birds did not physically examine Robert H., rather he prescribed over the telephone.

64. On or about November 10, 1989, Robert H. became acutely short of breath and turned blue due to lack of oxygen. Paramedics were called and Robert H. was admitted to San Pedro Peninsula Hospital where he was diagnosed with adult respiratory distress syndrome secondary to PCP. On admission, Robert H.'s condition was grave and his survival "improbable."

65. On or about November 16, 1989, Robert H. died due to cardiopulmonary arrest.

66. As a result of the conduct described in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of their gross negligence and incompetence in failing to perform a physical examination, take an adequate medical history, or formulate a treatment plan based on a diagnosis of Robert H.'s ailment(s).

67. As a result of the conduct described in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to section 2234, subdivisions (b), (d) and (e) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.

68. As a result of the conduct described in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their gross negligence in failing to obtain approval, as required by law, from regulatory agencies prior to administration of the substance "Viroxan" to human beings.

69. As a result of the conduct described in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their acts of gross negligence in administering, or making available to patients for self-administration a substance which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

70. As a result of the conduct described in Paragraphs 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of their gross negligence and incompetence in failing to timely recognize the presenting symptoms of

Pneumocystis cariini pneumonia (PCP), and failing to initiate chemoprevention against PCP.

71. As a result of the conduct described in Paragraphs 51-65 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because he was grossly negligent in that: He prescribed inadequate doses of Bactrim; He prescribed Bactrim over the telephone to a sulpha allergic patient; He failed to monitor his patient's use of the Bactrim; and, He failed to hospitalize his patient.

72. As a result of the conduct described in Paragraphs 51-65 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivision (e) because of his dishonest or corrupt act in using a diagnosis of lymphoma to justify admission of Robert H. to the hospital for placement of a Hickman catheter.

73. Respondents Herman and Birds are subject to disciplinary action pursuant to section 2234, subdivisions (b) and (d) based on their gross negligence and incompetence in recommending and referring Robert H. to a surgeon for insertion of a Hickman catheter without adequate medical indication, especially when respondents knew, or should have known that Robert H. was severely immunocompromised. Respondents failed to properly advise Robert H. of the potential lethal complications of such a procedure and the extremely low likelihood of any benefit.

74. As a result of the conduct described in Paragraphs 51-65 above, respondent Birds is subject to disciplinary action

pursuant to Code section 2234, subdivision (d) because of his incompetency in using typhoid vaccine without proper medical indication.

75. As a result of the conduct describe in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their gross negligence in treating an AIDS patient by self-administered intravenous infusion, their failure to instruct the patient on proper sterile injection technique, and their failure to monitor the patient's home use of a foreign substance by parenteral delivery.

76. As a result of the conduct described in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (c) because of their repeated negligent acts in the treatment of Robert H. in that they: failed to keep adequate medical records; they failed to properly diagnose Robert H.'s medical condition; and, failed to initiate proper chemoprevention against Pneumocystis cariini Pneumonia (PCP).

PATIENT RONALD M.

77. On or about December 18, 1989, Ronald M. was diagnosed as having AIDS related complex (ARC.)

78. On or about May 15, 1989, Ronald M. was diagnosed as having encephalitis due to HIV ("AIDS dementia").

79. On or about August 14, 1989, Ronald M. became one of respondent Birds' patients.

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80. On or about August 17, 1989, without reviewing Ronald M.'s medical records, respondent Birds began Ronald M. on a "therapeutic protocol using typhoid vaccine." These "treatments" continued until approximately November 1, 1989.

81. On or about August 25, 1989, respondent Birds began administering Oncovin (Vincristine) intravenously to Ronald M.

82. Billing slips from respondent Birds' office indicate Ronald M. saw respondent Birds on November 1, 1989, November 8, 1989, and December 5, 1989, however, there are no medical/chart records after October 30, 1989.

83. On or about November 3, 1989, Ronald M. had a "Landmark" catheter inserted in his left arm to facilitate respondent Herman's treatment of Ronald M. with "Viroxan".

84. On or about November 6, 1989, Ronald M. visited respondent Herman at respondent Herman's Orange County home. Respondent Herman noted that Ronald M. was HIV+; 34y/0; T415; severe debilitation and KS; diarrhea; severe neurological damage." No further history was noted, nor was a physical examination done. Nonetheless, respondent Herman prescribed two thousand milligrams of "Viroxan" IV and noted the dosage would increase to four thousand milligrams after a Hickman catheter was placed in Ronald M.

85. On or about November 7, 1989, Ronald M. again visited respondent Herman and was administered three thousand milligrams "Viroxan" IV.

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86. On or about November 8, 1989, respondent Birds admitted Ronald M. to the Medical Center of North Hollywood for insertion of a Hickman catheter so Ronald M. could "start a chemotherapy program that requires daily IV medication...". A double-lumen Hickman catheter was placed in Ronald M. and the "Landmark" catheter removed.

87. On or about November 22, 1989, Ronald M. developed a cough and began experiencing difficulty swallowing.

88. On or about December 5, 1989, Ronald M. saw respondent Birds at respondent Birds' office, as indicated by a billing slip, however, respondent Birds failed to make any physician notations concerning the visit.

89. On or about December 6, 1989, Ronald M. was taken to Kaiser Anaheim Emergency room because of high fever, chills and mental confusion. Ronald M. was admitted to the hospital and treated with antibiotics for bacteria infection resulting from the Hickman catheter site and/or contamination due to self-injections with "Viroxan".

90. On or about December 15, 1989, Ronald M. suffered cardiopulmonary arrest.

91. On December 24, 1989, Ronald M. died.

92. As a result of the conduct described in Paragraphs 77-91 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of their gross negligence and incompetence in failing to perform a physical examination, take an adequate

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medical history, or formulate a treatment plan based on a proper diagnosis of Ronald M.'s ailment(s).

93. As a result of the conduct described in Paragraphs 5-9 and 77-91 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (d) and (e) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.

94. As a result of the conduct describe in Paragraphs 5-9 and 77-91 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in failing to obtain investigational approval, as required by law, from regulatory agencies prior to administering the substance "Viroxan" to human beings.

95. As a result of the conduct described in Paragraphs 5-9 and 77-91 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in administering, or making available to patients for self-administration a substance which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

96. As a result of the conduct describe in Paragraphs 5-9 and 77-91 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in treating a patient with "AIDS dementia"

by self-administered intravenous infusion, his failure to instruct the patient on proper sterile injection technique, and his failure to monitor the patient's home use of a foreign substance by parenteral delivery.

97. As a result of the conduct described in Paragraphs 77-91 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivision (d) because of his incompetency in using typhoid vaccine without proper medical indication.

98. As a result of the conduct described in Paragraphs 77-91 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (d), and (e) because of his gross negligence, incompetence, and dishonesty or corruption in ordering a Hickman catheter inserted in Ronald M. chest without proper medical indication for the Hickman catheter when respondent Birds knew, or should have known that Ronald M. was severely immunocompromised; and, by failing to properly advise Ronald M. of the potential lethal complicationsof such a procedure and the extremely low likelihood of any benefit.

99. As a result of the conduct described in Paragraphs 77-91 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (c) because of their repeated negligent acts in failing to keep adequate medical records of their treatment of Ronald M., their failure to make a proper professional assessment of Ronald M.'s medical condition, their failure to instruct Ronald M. on proper sterile injection techniques, their failure to monitor his use of

a foreign substance, their failure to present Ronald M. with options other than the substance "Viroxan" for treatment of HIV infection, their failure to properly monitor Ronald M.'s medical condition, and their failure to refer Ronald M. to a recognized medical specialist.

PATIENT MICHAEL K.

100. Michael K., an HIV infected individual, became a patient of respondent Herman on or about September 12, 1989. On or about that date, when Michael K. visited respondent Herman, respondent Herman failed to perform any type physical examination. Nonetheless, respondent Herman started Michael K. on "Viroxan" via intramuscular injection in Michael K.'s Gluteus Maximus muscle.

101. Michael K. self-injected "Viroxan" daily until he developed a black "eschar" at the injection site and began experiencing extreme pain. Consequently, sometime between September 12, 1989 and October 24, 1989, pursuant to respondent Birds order, Michael K. had a Hickman catheter implanted in his chest so he could inject "Viroxan" intravenously on a daily basis. Even after installation of the Hickman catheter Michael K. continued experiencing pain in his right gluteal area.

102. On or about November 13, 1989, Michael K. began undergoing a series of excisions of his right buttock.

103. On or about December 7, 1989, Michael K. was admitted to Eisenhower Memorial Hospital for extensive debridement of a deep muscle abscess in his right buttock. (Pathology of the debrided tissue demonstrated necrotic material

of the right buttock. There was necrosis extending deep into the subcutaneous tissue and skeletal muscle.) Michael K. remained in Eisenhower Memorial Hospital for fifteen days and was treated for toxic shock syndrome secondary to the gluteal wound.

104. On or about January 15, 1990, Michael K. was again admitted to Eisenhower for recurrent toxic shock.

105. On or about January 26, 1990, Michael K. was again admitted to Eisenhower Memorial Hospital after being found in a stuporous state due to injection of an overdose of methadone, elavil, and a anxiolytic agent. Chest X-rays of Michael K. revealed bilateral interstitial infiltrates, and Michael K. was treated for PCP until his death on February 4, 1990.

106. An autopsy revealed Michael K. had "bilateral staphylococcal pneumonia" and "massive ulceration of the right buttock." It was determined that the gluteal abscess resulted from contamination due to regular intramuscular injection of "Viroxan" supplied by respondent Herman.

107. As a result of the conduct described in Paragraphs 5-9 and 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.

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108. As a result of the conduct described in Paragraphs 5-9 and 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in administering and/or making available to patients, a substance ("Viroxan"), which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

109. As a result of the conduct describe in Paragraphs 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in treating an AIDS patient by self-administered intravenous infusion, his failure to instruct the patient on proper sterile injection technique, and his failure to monitor a patient's home use of a foreign substance by parenteral delivery.

110. As a result of the conduct described in Paragraphs 5-9 and 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in failing to obtain investigational approval, as required by law, from regulatory agencies prior to administering the substance "Viroxan" to human beings.

111. As a result of the conduct described in Paragraphs 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of his gross negligence and incompetence in failing to timely recognize the presenting symptoms of

Pneumocystis cariini pneumonia (PCP), and failing to initiate chemoprevention against PCP.

112. As a result of the conduct described in Paragraphs 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of his gross negligence and incompetence in failing to perform a physical examination, take an adequate medical history, or formulate a treatment plan based on a diagnosis of Michael K.'s ailment(s).

113. As a result of the conduct described in Paragraphs 100-106 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (d), and (e) because of his gross negligence, incompetence, and dishonest or corrupt act of recommending and referring Michael K. to a surgeon for the purpose of having a central indwelling Hickman catheter inserted through his chest even though respondent Birds knew or should have known Michael K. was severely immunocompromised. Respondent Birds also failed to properly advised Michael K. of the potential lethal complication of such a procedure and the extremely low likelihood of any benefit.

114. As a result of the conduct described in Paragraphs 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (c) because of his repeated negligent acts in failing to keep adequate medical records of his treatment of Michael K., his failure to make professional assessment of Michael K.'s medical

condition, his failure to instruct Michael K. on proper sterile injection techniques, his failure to monitor Michael K.'s use of a foreign substance, his failure to present Michael K. with options other than the substance "Viroxan" for treatment of HIV infection, his failure to monitor Michael K.'s medical condition, and his failure to refer Michael K. to a recognized medical specialist.

PATIENT CHRIS A.

115. On or about September or October 1989, Chris A., an HIV infected individual, became one of respondent Herman's patients. Respondent Herman supplied Chris A. with "Viroxan" after representing to Chris A. that "Viroxan" would ameliorate HIV infection. Respondent Herman administered, and/or instructed Chris A. to self-inject "Viroxan" into his buttocks.

116. Chris A. self-injected "Viroxan" intramuscularly into his right buttock until respondent Birds directed placement of a Hickman catheter. The Hickman catheter was placed in Chris A.'s chest on or about October 10, 1989.

117. Eventually Chris A. began experiencing pain and swelling in his right buttock. Chris A. contacted respondent Herman by telephone and respondent Herman, without physically examining Chris A., prescribed an antibiotic, Keflex.

118. On or about December 10, 1989, due to pain and swelling in his right buttock, Chris A. went to the emergency room at Eisenhower Memorial Hospital in Rancho Mirage. Chris A. had a gluteal abscess (similar to that experienced by Michael K.) and was given an intravenous dose of an antibiotic.

119. On or about December 11, or 12, 1989, Chris A. was admitted to Eisenhower Memorial Hospital because of deterioration in his condition. Chris A. was diagnosed as having an abscess of his right buttock with muscle necrosis (mummification) secondary to intramuscular injection. Chris A.'s condition required debridement of a 16 X 18 cm area of his right buttock.

120. Although respondent Herman made "Viroxan" available to Chris A. and prescribed an antibiotic over the telephone, respondent Herman kept no medical records concerning Chris A.

121. As a result of the conduct described in Paragraphs 115-120 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of his gross negligence and incompetence in failing to perform a physical examination, take an adequate medical history, or formulate a treatment plan based on a diagnosis of Chris A.'s ailment(s).

122. As a result of the conduct described in Paragraphs 5-9 and 115-120 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.

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123. As a result of the conduct described in Paragraphs 5-9 and 115-120 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in failing to obtain investigational approval, as required by law, from regulatory agencies prior to administering the substance "Viroxan" to human beings.

124. As a result of the conduct described in Paragraphs 5-9 and 115-120 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in administering and/or making available to patients, a substance ("Viroxan"), which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

125. As a result of the conduct describe in Paragraphs 115-120 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in treating an AIDS patient by self-administered intravenous infusion, his failure to instruct the patient on proper sterile injection technique, and his failure to monitor a patient's home use of a foreign substance by parenteral delivery.

126. As a result of the conduct described in Paragraph 117 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in prescribing an antibiotic over the telephone without physically examining the patient.

127. As a result of the conduct described in Paragraphs 115-120 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (d) and (e) because of his gross negligence, incompetence, and fraud in recommending and referring Chris A. to a surgeon for the purpose of having a central in-dwelling Hickman catheter inserted through his chest even though respondent Birds knew or should have known that Chris A. was severely immunocompromised. Furthermore, respondent Birds failed to properly advise Chris A. of the potential lethal complications of such a procedure and the extremely low likelihood of any benefit.

128. As a result of the conduct described in Paragraphs 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (c) because of his repeated negligent acts in failing to keep adequate medical records of his treatment of Chris A., his failure to make professional assessment of Chris A.'s medical condition, his failure to instruct Chris A. on proper sterile injection techniques, his failure to monitor Chris A.'s use of a foreign substance, his failure to present Chris A. with options other than the substance "Viroxan" for treatment of HIV infection, his failure to monitor Chris A.'s medical condition, and his failure to refer Chris A. to a recognized medical specialist.

PATIENT DAVID P.

129. On or about June 1, 1989, David P. was admitted to LAC-USC Medical Center, Psychiatric Ward because of suicidal

tendencies. After discharge from the Psychiatric Unit, a Chiropractor David P. saw recommended David P. see respondent Birds.

130. On or about June 21, 1989, David P. became one of respondent Birds' patients. During the June 21, 1989 office visit, respondent Birds took a brief medical history but did not physically examine David P. Furthermore, respondent Birds did not include a psychiatric history and therefore failed to discover David P.'s past psychiatric problems.

131. On or about June 21, June 27, and July 18, 1989, respondent Birds ordered laboratory tests to be performed on blood samples obtained from David P. The tests included a CD4-T-cell count, p-24 antigen assay. No HIV antibody test was ordered. The tests disclosed mild normochromic, normocytic anemia. However, respondent Birds failed to initiate any type diagnostic "work-up." The laboratory tests also revealed an elevated base line measurement of herpes (I and II) IgG serum antibody titters. Respondent Birds concluded David P. had "herpes-long term--under stress--brain changes."

132. On or about July 25, 1989, respondent Birds started David P. on a "Therapeutic protocol using typhoid vaccine".

133. On or about November 6, 1989, respondent Birds recommended David P. visit respondent Herman for help with the herpes infection.

134. On or about November 13, 1989, David P. returned to respondent Birds for a medical history and physical examination in preparation for insertion of a Hickman catheter. On or about November 14, 1989, pursuant to respondent Birds' order, David P. had a Hickman catheter placed. Respondent Birds admission history and physical examination of David P. stated he had "lymphatic enlargement in axillary, cervical and inguinal area, most likely of a viral nature but of a lymphocytic type problem."

135. On or about November 15, 1989, David P. visited respondent Birds and respondent Birds gave David P. his first treatment with "Viroxan" which had been prescribed and provided by respondent Herman. Respondent Birds showed David P. how to self-administer the "Viroxan" via an IV drip.

136. Sometime during early December 1989, David P. moved back home to San Antonio, Texas. While in Texas, David P. talked with both respondent Birds and respondent Herman via telephone and the respondents sent David P. "Viroxan" through the mail. David P. continued to self-inject "Viroxan" through the Hickman catheter until approximately January 17, 1989, when, pursuant to the advise of another physician, David P. discontinued using "Viroxan".

137. As a result of the conduct described in Paragraphs 5-9 and 129-136 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b), and (d) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in

administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.

138. As a result of the conduct described in Paragraphs 5-9 and 129-136 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in failing to obtain investigational approval, as required by law, from regulatory agencies prior to administering the substance "Viroxan" to human beings.

139. As a result of the conduct described in Paragraphs 5-9 and 129-136 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in failing to ascertain whether or not investigational approval existed from regulatory agencies prior to administration of the substance "Viroxan" to human beings.

140. As a result of the conduct described in Paragraph 5-9 and 129-136 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) for their gross negligence in administering and/or making available to patients, a substance ("Viroxan"), which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

141. Respondents Herman and Birds are subject to disciplinary action pursuant to section 2234, subdivisions (b),

(d), (e) based on their gross negligence, incompetence, and dishonesty or corruption in recommending and referring David P. to a surgeon for insertion of a Hickman catheter without adequate medical indication, especially when respondents knew, or should have known that David P. was severely immunocompromised. Respondents failed to properly advise David P. of the potential lethal complications of such a procedure and the extremely low likelihood of any benefit.

142. As a result of the conduct described in Paragraphs 129-136 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their gross negligence in treating an AIDS patient by self-administered intravenous infusion, their failure to instruct the patient on proper sterile injection technique, and their failure to monitor a patient's home use of a foreign substance by parenteral delivery.

143. As a result of the conduct described in Paragraphs 129-136 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of his gross negligence and incompetence in failing to perform a physical examination, take an adequate medical history, or formulate a treatment plan based on a diagnosis of David P.'s ailment(s).

144. As a result of the conduct described in Paragraphs 5-9 and 129-136 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivision (d) because of his incompetency in using typhoid vaccine without

proper medical indication.

145. As a result of the conduct described in Paragraphs 129-136 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (c) because of their repeated negligent acts in failing to keep adequate medical records of their treatment of David P., their failure to make professional assessment of David P.'s medical condition, their failure to instruct David P. on proper sterile injection techniques, their failure to monitor his use of a foreign substance, their failure to present David P. with options other than the substance "Viroxan" for treatment of HIV infection, their failure to monitor David P.'s medical condition, and their failure to refer David P. to a recognized medical specialist.

PATIENT STANLEY H.

146. Stanley H., an HIV infected individual began "Viroxan" treatment with respondent Herman on or about June 21, 1989.

147. Stanley H. injected "Viroxan" by peripheral vein in various doses. Eventually, Stanley H. began having "trouble with his veins" due to the "Viroxan" injections. Accordingly, respondent Herman referred Stanley H. to respondent Birds for placement of a Hickman catheter.

148. On or about December 12, 1989, Stanley H. was admitted to the Medical Center of North Hollywood by respondent Birds for insertion of a Hickman catheter. According to Respondent Birds, the catheter was necessary "to allow for IV

therapy for the infection and the evidence of lymphocytic enlargement. Possible viral lymphoma type reaction to be considered as the cause." No explanation was given by respondent Birds concerning the nature of the "developing lymphocytic enlargement or the developed viral lymphoma." There was also no explanation of the type therapy contemplated which required insertion of a Hickman catheter.

149. Stanley H. received a Hickman catheter on or about December 12, 1989, and was discharged from the hospital that same day. Stanley H. began using the Hickman catheter for self-administration of "Viroxan" obtained from respondent Herman.

150. On or about January 15, 1990, Stanley H. was admitted to Fountain Valley Regional Hospital and Medical Center for possible blood poisoning (Septicemia) caused either by the Hickman catheter site or contaminated "Viroxan". On admission, Stanley H. reported a two-week history of fever, shaking, chills, headaches, and increased respirations.

151. Although Stanley H. received medical treatment from respondent Herman, respondent Herman kept no medical records concerning his evaluation or treatment of Stanley H.

152. As a result of the conduct described in Paragraphs 146-151 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of his gross negligence and incompetence in failing to perform a physical examination, take an adequate medical history, or formulate a treatment plan based on a diagnosis of Stanley H.'s ailment(s).

153. As a result of the conduct described in Paragraphs 5-9 and 146-151 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (d), and (e) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.

154. As a result of the conduct described in Paragraphs 5-9 and 146-151 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in failing to obtain investigational approval, as required by law, from regulatory agencies prior to administering the substance "Viroxan" to human beings.

155. As a result of the conduct described in Paragraphs 5-9 and 146-151 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in administering and/or making available to patients, a substance ("Viroxan"), which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

156. As a result of the conduct described in Paragraph 5-9 and 146-151 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in treating an AIDS patient

by self-administered intravenous infusion, his failure to instruct the patient on proper sterile injection technique, and his failure to monitor a patient's home use of a foreign substance by parenteral delivery.

157. As a result of the conduct described in Paragraphs 146-151 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (d), (e) based on their gross negligence, incompetency, and dishonesty or corruption in recommending and referring Stanle H. to a surgeon for insertion of a Hickman catheter without adequate medical indication, especially when respondents knew, or should have known that Stanley H. was severely immunocompromised. Respondents failed to properly advise Stanley H. of the potential lethal complications of such a procedure and the extremely low likelihood of any benefit.

158. As a result of the conduct described in Paragraph 5-9 and 146-151 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of their gross negligence and incompetence in failing to perform a physical examination, take an adequate medical history, or formulate a treatment plan based on a diagnosis of Stanley H.'s ailment(s).

159. As a result of the conduct described in Paragraphs 146-151 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (c) because of their repeated negligent acts in failing to keep adequate medical records of their treatment of

Stanley H., their failure to make professional assessment of Stanley H.'s medical condition, their failure to instruct Stanley H. on proper sterile injection techniques, their failure to monitor his use of a foreign substance, their failure to present Stanley H. with options other than the substance "Viroxan" for treatment of HIV infection, their failure to monitor Stanley H.'s medical condition, and their failure to refer Stanley H. to a recognized medical specialist.

160. As a result of respondent Herman's and respondent Birds' custom and habit or modus operandi evidenced by their pattern and conduct in treating patients, and aiding and abetting each other in treating patients, as described in Paragraphs 5-14, 20-21, 23-40, 51-65, 77-91, 100-106, 115-120, 129-136, and 146-151, above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (c), (d), (e), for their gross negligence, repeated negligent acts, incompetence, and dishonesty and corruption in treating patients with "Viroxan" and ordering Hickman catheters to be placed in the patients without proper medical indication notwithstanding the fact respondents knew, or should have known the patients were at extremely high risk of infection because they were immunocompromised. Respondents' conduct was exacerbated further by their continued neglect of patients as evidenced by their lack of proper medical records, and failure to monitor patients home use (self-injection) and progress while using "Viroxan", a substance toxic to laboratory animals and unproven as effective in treating AIDS, HIV positive patients,

arthritis, cancer, or any other ailment.

WHEREFORE, Complainant requests the Board hold a hearing on the matters alleged herein; and, following said hearing, the Board issue a decision:

1. Revoking or suspending respondent Herman's and respondent Birds' physician and surgeon licenses;

2. Revoking or suspending respondent Birds' license to supervise physician assistants; and,

3. Taking such other and further action the Board deems appropriate to protect the public health, safety and welfare.

DATED: May 17, 1991

Kenneth Wagstaff
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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